Please Mail in Both Copies

REQUEST FOR CERTIFIED COPY

Record Name: First	Middle	Last

Date of Event (Month/Day/Year)	County Where Event Occurred
Maiden Name of Mother (For Birth Only)	**Infant's Hospital of Birth**

Copies Requested

_____ Birth $15.00 ☐ Long Form ☐ Abstract (Excludes some data [*i.e.*, Dr., Hospital])

_____ Death $ 8.00 ☐ Veterans' Administration Copy

Amount Enclosed — ***DO NOT SEND CASH*** —

$ _____ ☐ Check ☐ Money Order ☐ Pick Up

MAIL TO:

County of San Bernardino
DEPARTMENT OF PUBLIC HEALTH
351 North Mountain View Avenue
San Bernardino, CA 92415-0010

RECORD REQUESTED BY:

Name
Address
City **State** **Zip Code**

16-6454-611 Rev. 7/99
011.018.H13R8/97